Division of Public and Behavioral Health
Bureau of Public and Behavioral Health Wellness and Prevention
Statewide Epidemiology Workgroup

MINUTES

DATE: January 18, 2018
TIME: 9:00 a.m.

	Meeting	Videoconference
LOCATION:	**Division of Public and Behavioral Health**	**Southern Nevada Adult Mental Health Services**
	4126 Technology Way	**6161 W. Charleston Blvd.**
	2nd Floor Conference Room	**East Hall Conference Room**
	Carson City, NV 89706	**Las Vegas, NV 89146**

BOARD MEMBERS PRESENT

Julia Peek, Deputy Administrator, Division of Public Behavioral Health (DPBH)
Brandon Delise, Southern Nevada Health District, on behalf of Kathryn Barker
Eric Ohlson, Washoe County School District
Ingrid Mburia, DPBH, Maternal Child Health Services (MCHS)
James Kuzhippala, Truckee Meadows Community College
Jennifer DeLett-Snyder, Join Together Northern Nevada (JTNN)
Marco Erickson, Substance Abuse Prevention and Treatment Agency (SAPTA)
Pauline Salla, Division of Child and Family Services, Juvenile Justice Programs Office
Richard Egan, Office of Suicide Prevention
Stephanie Asteriadis Pyle, Center for the Application of Substance Abuse Technologies (CASAT), University of Nevada, Reno (UNR)
Yenh Long, Board of Pharmacy
Ihsan Azzam, Epidemiologist, DPBH
Judy Henderson, Nevada Coalition to End Domestic and Sexual Violence, on behalf of Sue Meuschke
Trey Delap, Group Six Partners
Ying Zhang, Southern Nevada Health District

BOARD MEMBERS ABSENT

Gwen Taylor, African-American Community Cultural Education Programs and Training (ACCEPT)
Jim Jobin, Vogue Recovery Center
John Fudenberg, Clark County Coroner
Wei Yang, NV Center for Health Stats and Information, UNR

OTHERS PRESENT

Blayne Osborn, Nevada Rural Hospital Partners
Lea Cartwright, Nevada Psychiatric Association
Janet Porter, CASAT
Victoria LeGarde, CASAT
Natalie Powell, CASAT

SAPTA/STATE STAFF PRESENT

Elyse Monroy, Health and Human Services Policy Analyst, Office of the Governor
Terry Kerns, Law Enforcement Substance Abuse Coordinator, Office of the Attorney General
Brian Parrish, DPBH
Kyra Morgan, Office of Public Health Information and Epidemiology (OPHIE)
Bill Kirby, SAPTA
Raul Martinez, SAPTA
Joan Waldock, SAPTA
Megan Messerly, The Nevada Independent

1. Introductions, Announcements, and Roll Call

Ms. Peek called the meeting to order at 9:04 a.m. and noted there was a quorum present. She asked that announcements, staffing changes, or programmatic highlights be shared.

Ms. Mburia reported that the Pregnancy Risk Assessment Monitoring System (PRAMS) started data collection in September. Ms. Kerns reported that her primary goal is to improve coordination and data sharing with law enforcement, public health, and the health care industry. Ms. Henderson stated that her organization is completing an online toolkit of resources for health care providers, by discipline, with tips on how to screen for abuse. Dr. Asteriadis Pyle said big changes were coming in the next couple of months.

Ms. Morgan said there have been significant staffing changes as they centralized their analytic resources for all Department of Health and Human Services divisions into one unit in the Director's office. Jen Thompson filled their Health Program Specialist II position and oversees data analytics unit for the group. Ms. Peek said the centralized analytic unit is better for getting data because it allows access to data from other partners—Medicaid, Division of Child and Family Services, Aging and Disability Services, and Welfare eligibility, noting that few states have access to this level of data. Data requests should be to data@dhhs.nv.gov. Ms**.** Morgan will review requests and get them to the right people. Ms. Peek and Ms. Morgan will work together to prepare data for the regional behavioral health boards.

Ms. Cartwright announced that the Nevada Psychiatric Association will host a psychopharmacology conference in Las Vegas in February. It is available to health care professionals for continuing medical education continuing education units in suicide prevention awareness and opioid overdose. Mr. Egan reported that Nevada moved from eleventh back to fifth in the nation for suicides; the number of suicides jumped from 558 to 650 between 2015 and 2016. Nevada is back at number one for suicides of people 65 years and older. For Nevadans ages 8 to 17, suicide was the leading cause of death. There was a reduction in the number of suicides by firearms—Nevada is now equal with the nation, at 51%. In the past, Nevada was at 57%. He added there was also a decrease in suicides among males, putting Nevada below the national average. Much discussion followed.

Ms. Salla reported implementation of a new case management system for tracking data. They also rolled out a new risk and needs assessment that captures children with comorbid disorder so effective referral services to treatment organization can be provided. Both systems have been adopted statewide for all probation departments' use and for state youth parole and correctional facilities.

Ms. Peek said the Southern Nevada Health District has been working with Ms. Kerns to start a pilot program for ODMAP. Ms. Kerns explained that ODMAP is a free app and software from High Intensity Drug Trafficking areas (HIDTA) out of the Washington, D.C./Baltimore area. It is used to track overdoses. Nevada will pilot it with an emergency medical services (EMS) provider in southern Nevada. It should provide information about spikes in overdoses that is currently unavailable. She said she sat with an EMS provider, looking at 483 overdose calls they responded to from January 1 to October 31. Dispatch data for overdoses would show only one-fourth to one-third of them. They pulled calls for heart attacks, unconscious patients, or patients with difficulty breathing in order to get all the data on overdoses, as many 911 calls were not for known overdoses. The criteria used to determine overdose was if Narcan was given. When looking at the data, they discovered that while they had been averaging three to four overdoses a day, there was one day with eight or nine overdoses. If the data is entered into ODMAP, the State would be alerted about such spikes within 24 to 48 hours. With that information, the State might be able to identify why the spikes took place. Working with the Health Department, the State could put out information through the Fusion Center to EMS, hospitals, and treatment facilities. Law enforcement could be alerted. Ms. Peek said the program would close one of the gaps—lack of real-time data collection. The syndromic surveillance system used is the Electronic Surveillance for the Early Notification of Community-Based Epidemics (ESSENCE) Program which is de-identified chief

complaint data in emergency rooms (ERs). The challenge with EMS data is that there could be multiple reasons a patient was unresponsive, so it will show more cases of potential overdose than suspected. Mr. Parrish reported that the Centers for Disease Control (CDC) has workgroups that are looking at overdose reporting for the ESSENCE system. They developed queries and codes to run within ESSENCE that do the best job they can of filtering out the ones that are not opioid overdose related. He said anyone with questions regarding the codes or anyone wanting to be involved in the workgroups should contact him at bparrish@health.nv.gov. The CDC's main objective is to work with states to develop codes that will best filter out the chief complaint data not actually overdose related. CDC is developing a Morbidity and Mortality Weekly Report (MMWR) on the topic. Dr. Azzam asked if they were cuing deaths due to overdoses or just to morbidity. He suggested they might be able to predict the day of a spike. Ms. Kerns said when the data is in the system they could start to look at that. Dr. Azzam asked if the information could identify those who were at risk of overdose by category. He thought if categories could be identified, then prevention could target the groups at highest risk. Ms. KERNS said ODMAP is anonymous information, but she would like to look at EMS data for that information. Ms. Peek added that other data systems cross-tabulate with different sources to help the State understand where prevention efforts should be directed. One goal of SEW is to provide that data to prevention and treatment stakeholders through the Multidisciplinary Prevention Advisory Committee, the Governor's accountability meetings for opioid abuse, and through boards. That information includes morbidity and mortality data, although mortality data is delayed by about six months because of the wait for toxicology results for cause of death. Ms. Morgan replied there is an online document updated regularly that shows hospitalizations—both in ERs and inpatient, as well as deaths related to opioids in general. It can be found here. It also gives information specific to poisonings or overdoses. Mr. Parrish added that hospitals are asked to report morbidity data daily for ESSENCE.

Mr. Parrish reported that OPHIE has added new staff. In February, there will be a new management analyst who will help with the Behavioral Risk Factor Surveillance System (BRFSS). Petra Bartella is the new Grants and Projects Analyst who will help with opioid grant-related deliverables. Ali Garcia, the new disease investigator, is working out of the Reno office with a majority of the OPHIE staff, but there is still staff in both Carson City and Las Vegas.

Ms. Long reported AB 474, the controlled substance prevention act, was signed into law in June, and became effective January 1. The Board of Pharmacy has provided education to practitioners regarding the new law and how to implement it into their practices, and to pharmacies regarding the new requirements added to prescriptions before they can be filled. With that bill alone, the Board of Pharmacy has received numerous phone calls. There had been an 85 to 95% registration rate with the Prescription Monitoring Program (PMP). The remainder are now registering with the PMP, calling to find out how to use the system, asking how to add delegates to the system. Ms. Long's office has been answering questions from all licensees—nurses, doctors, dentists—about the new law. They are implementing the law and enforcing the use of the PMP. In March, they will move to look for noncompliance with the law as AB 474 gave them the duty to report fraudulent or suspected unauthorized activities of the PMP to the licensing board. They have pointed practitioners to Prescribe 365.nv.gov which contains a wealth of information. It has sample informed consent forms, patient agreement forms, and other resources. Ms. Peek added that Senate Bill (SB) 59 would also increase the data collected through the PMP, including data from law enforcement and the coroners. Ms. Monroy asked if the bill required schedule V drugs to be reported. Ms. Long replied that SB 59 required pharmacies to report controlled substances to the PMP, including schedule V controlled substances. They are primarily concerned about promethazine and codeine—a problem exists with fraudulent prescriptions being written because the combination has become a popular party drink that can be sold on the black market for $600 to $1,000 per pint. If there is a report of a stolen prescription, law enforcement has to put the information into the PMP. If the coroner determines that a patient overdosed due to any kind of

controlled substance, that information must be reported to the PMP. Since these functions were not built into the PMP, the logistics are still being worked out.
Ms. Peek said that, as a result of AB 474, they are getting reports that some physicians will no longer prescribe opioids at all. From a data perspective, they are interested in watching that. Ms. Long will weekly track the aggregate number of prescriptions. Ms. Long said, based on preliminary findings, there has been a decrease in the number of controlled substances prescribed and dispensed.
Ms. Powell reported that the executive director of CASAT did a slide comparing opioid deaths to car accidents and plane crashes so that people can put the information into perspective. She will forward the information.

2. Public Comment
   There was no public comment.

3. Update on Web Infrastructure for Treatment Services (Marco Erickson)
   Ms. Peek asked Mr. Erickson to talk about WITS, how the TEDS data will be required for SAPTA-certified providers, and how that will add to the data.
   Regarding WITS, Mr. Erickson said they have been building the capacity for Nevada to implement prevention, treatment, contract management, and the data repository. The data repository connects agencies' individualized EHRs and their ability to report TEDS data. In the past, only providers directly funded by SAPTA through federal grants reported TEDS data. It will now be required of all providers. Once WITS is implemented, the data will come in quickly. The data repository will be built to accept and tabulate it. He reported they collecting the particular data needed in Nevada, looking at what other states are doing in order to come up with how to keep the information safe. The base piece should be ready in late March or early April. FEi Systems will provide WITS, which is being used in close to 30 states. Other states can provide training on what has been done before. Nevada may borrow some things, but will add things specific to Nevada's needs which FEi will have to build. FEi will be here February 6-8, meeting with State people, having discussions on some of the modules with community partners. He suggested that any interested in attending email him directly at maerickson@health.nv.gov. The contract management discussion will be on February 6. The prevention portion will be on February 7, covering what needs to be reported to the feds. There will be one place where all of the information is gathered, so staff will no longer have to pull from multiple sources. On February 8, FEi will talk about the data repository and the treatment pieces.
   Ms. Peek commented that getting TEDS data from all SAPTA-certified providers is important because the data on treatment, why people were coming in, and what substances they were using was severely limited. The Division has had to identify that the data was from a subset of providers. Ms. Peek asked whether all treatment providers were required to be SAPTA-certified, or if they only had to be certified if they want to be able to accept certain insurances. Mr. Erickson said they are not required by the State to be SAPTA-certified, but insurances may require it as certification assures a level of quality. This will allow the State to identify population health—by substance, by age, by demographic, or by geographic information. Ms. Morgan said the March/April date mentioned is for WITS implementation. Not all statewide providers will be submitting data by March. She said she had a meeting scheduled for this afternoon to work on a communication plan with those providers. Only 10% of agencies are SAPTA-funded, currently reporting as required. It will be a heavy lift to get the other 90% statewide substance abuse providers to comply. Mr. Erickson cautioned that this is a preliminary building and testing phase to work out the bugs. The State Targeted Response to the Opioid Crisis Grants (Opioid STR) sites will come on board as quickly as possible. They are still building components of the Opioid STR because they recently received what was required from the federal level. By next year, there should be a good start in the new data with a comprehensive look at how Nevada does compared to what was done in the past.

Dr. Azzam asked if reporting would be electronic. Mr. Erickson said that until that part of the system has been built, Excel spreadsheets will be used for data. If providers use their own EHRs, the Division will input data for them. Dr. Azzam asked if the system would be able to connect to other systems in use. Ms. Peek clarified he was asking if WITS could match across data systems. Ms. Morgan replied the system would not be electronically connected to other communicable disease systems but will have them both in-house, so they can be matched. Ms. Peek pointed out that this group wanted analysis and wondered which data sets they wanted to understand better when they are matched. The Division will look at deaths in the ER and the Prescription Drug Monitory Program (PDMP) related to opioids. Ms. Peek asked if a site using WITS as their EHR would have identifiers for treatment clients. If they did not, she wondered how to get the TEDS data and/or if the TEDS data coming into the repository was identifiable. Mr. Erickson said it would be identifiable by a formula WITS created that scrambles the information. Ms. Morgan disagreed—she thought information coming in through the data repository would not be identifiable because the TEDS data sent to the feds could not be identifiable. It requires use of a client ID, a scrambled combination of a person's identifiable information. She was unsure the data repository had fields to capture identifiable information, as it would not be extracted when the files go to the feds for TEDS reporting. Providers using WITS as their EHRs will have identifiable information. It is unclear whether information from other providers, sending extracts of data to the repository, is identifiable. Mr. Erickson said the Division would comply with all Health Insurance Portability and Accountability (HIPAA) requirements. Ms. Peek said the more data sets available with identifiers, the better the story of what is happening in the state can be told. Dr. Azzam said he would like to have information if a group of people with communicable diseases overused opioids or if individuals with chronic conditions were using them. The ultimate goal is to identifythose who are at risk because they are seen in greater proportion in the data set so they can be approached in education and prevention. Ms. Morgan said that analysis could be done, but will not be built into WITS, as it would require identifiers. Mr. Erickson said the current goal is to get WITS launched, but there will be an opportunity to tweak things later. If other states are interested in developing the same data Nevada wants, the cost can be shared with them.

4. Approval of Minutes from October 19, 2017 Meeting
   Ms. Peek said the only change needed is that James Kuzhippala now represents Truckee Meadows Community College. Mr. Egan moved to approve the minutes with that change. Ms. Mburia seconded the motion. The motion passed with none opposed.

5. Update on New Emergency Medical Service Reporting System
   Ms. Peek reported ImageTrend was selected as the new reporting system after a competitive request for proposal (RFP) process. The State will move to the new system in either April or July. It will provide a huge data set for what the Division wanted to look at. One of the challenges with EMS data is the delay of data entry into the current system—it has taken up to a month, if the data is entered at all. Data entry will be pushed when the new system is implemented. In general, EMS data has been challenging as it counts responses to an event—if multiple EMS agencies respond to an event, it will appear as an increase in the number of events, although it is only one event with multiple responders. The Division will work with the EMS team to dive into the data to understand how to use it. It will complement ODMAP. ODMAP is real time in certain locations; this data will be slightly delayed, but more complete.

6. Update on Criminal Justice Data
   Ms. Peek reported the Division has worked with law enforcement partners for years to get access to their identifiable data in order to see arrests related to substances or of persons with mental illness in order to understand what is occurring in the population served by DPBH. Full access to identifiable information from the Department of Corrections, the Division of Parole and Probation,

Lyon County, Carson City, and the Eighth Judicial District Court is now available. There have been requests to look at the effectiveness of specialty courts, so the State has gained access to the Eighth Judicial District Court data for drug court, mental health court, family court—all of their specialty courts. This allows a look at the effectiveness of certain programs and the effectiveness of mobile outreach and jail diversion programs by looking at arrests. Soon, Nevada-specific statewide data out of the Department of Public Safety's Criminal History Repository will be available. Ms. Peek did not think there would be a delay in data entry. This will allow a look at recidivism and reason for arrests. The data is identifiable, so it can be matched across other data systems. The file of statewide comprehensive arrests for any jail in Nevada will be sent on the first of each month. Once IT support has a server configured to receive the data, the data will be collected. Ms. Peek suggested thinking about what matching with this data set this group would like to see beyond PDMP and arrests. People not getting opioids from a health care provider might result in an increase in arrests related to access to some sort of controlled substance. Ms. Morgan will be point on that. Ms. Kerns will be an advocate for the getting criminal justice data. It is unknown what will be in the Criminal History Repository, so there may be additional data to get from criminal justice partners. Ms. Kerns can help make that connection. Regulations related to reporting of jail data, arrests, and medical information in the Criminal History Repository will be put forward. The medical information is not accessible in any other way. It is important to know how many inmates receive substance use services while incarcerated. As they exit, it is important to know how to help them with re-entry—to help them continue whatever services they were receiving while incarcerated and to ensure they stay current with their treatment. It is the same for mental health—whatever mental health services inmates received while incarcerated should be continued upon re-entry. Ms. Kerns said she assumes the Criminal History Repository would not include specialty courts as typically, for drug court, people go into treatment. She was curious to know about overdoses after release because many overdose after release because their substance tolerance is lower. Ms. Peek pointed out that those in the drug courts were arrested. The Criminal History Repository might include all convictions, whether or not a person ends up in jail or in specialty court. The specialty courts are like a jail diversion program, so the goal is to keep the person out of jail, but they have committed a crime. Ms. Peek clarified that she thought the Criminal History Repository contained records of arrests, not convictions.

Mr. Egan said he looked at the overdose of individuals after incarceration. When back in the community, many use at the same levels they were using prior to incarceration. Some overdose deaths may be attributed to the thinking they can go back to the same level they were using before. Ms. Kerns said from a prevention and education standpoint, that would be a good population to target. Ms. Peek added that it would be good to direct additional services to them at re-entry. This is why substance use information for while the person is incarcerated is needed so they can be offered services.

Ms. Mburia said her group would be interested in linking back to the birth data set to take a look at arrests of pregnant mothers and to find out if they were using substances or had any major health conditions. They would also want to look at blood outcomes—low blood rate, preterm birth, infant mortality and also if they received prenatal care. Prenatal care access rates are low and might be even lower for this population. Ms. Morgan said that could easily be done, although the Criminal History Repository will not show if they were on substances unless their conviction in drug-related. There is nothing in the repository related to a history of drug use. Ms. Peek pointed out that it is self-reported on the birth record, so that could be looked at. Mr. Delap asked about the intersection of criminal justice data and data related to care provided to people in custody in prison or in jail. He asked if any data regarding the kind of care provided to them was available. Ms. Morgan said this data set would not provide clinical information, but that would be pursued in the regulations. Ms. Peek explained that the regulations propose medical data reporting from the jails that would require that level of information. She sent draft regulations to the sheriffs, but they were not happy with them. She does not know if they will successfully pass the regulations. The other option

being pursued would connect the Electronic Medical Records (EMRs) at the Clark County Detention Center and Washoe County Detention Center to the Health Information Exchange to allow access to the information out of the repository they will be building. Naphcare, the vendor, has expressed interest in sharing that information because they want to ensure continuity of care upon re-entry. They also said it is important that people who are incarcerated understand their chronic conditions and whatever medication they were on. This encourages the exchange of health information across the board, regardless of setting.

Mr. Delap asked if Medication-Assisted Treatment (MAT) could be provided in Nevada prisons and jails. Ms. Monroy replied she thought it was permissible, the question would be if there was a person at the jail or prison with the training and medical specialty to safely administer treatment. Ms. Kerns said if someone was already receiving MAT and went to jail or prison, the medication could be delivered to be administered. She did not know if those incarcerated could start MAT while in jail or prison. Mr. Delap said the work that has been done is providing what has been missing from getting a good thumbnail sketch of the public health issue pursuant to opiates. The data needed about the people involved and the communities to protect are hitting all these cylinders—criminal justice, EMS, and hospitals. There are many opportunities for coding, miscoding, and duplication, but there are ways to validate data if it can be corroborated with data from other sources. If people receive treatment or some sort of mental health service while in custody, there must be a billing code or budget account that connect the information. In looking at this data in recent SEW meetings, the diagnosis does not provide all the information. Procedure codes are also valuable. A way to connect all the pieces into a unique identifier is the magic complete picture that would help informed decision-making. Ms. Peek appreciated that perspective, adding that it is helps to look at reports and see they are missing a procedure, diagnostic, or billing code. DPBH and Pacific Institute for Research and Evaluation (PIRE) staff are not clinicians, they are statisticians, so input is needed. The CDC has changed the way to report opioid information, so the data has changed with new national standards. With the International Classification of Disease (ICD)-10 change, there are differences, so feedback is important. Educating the folks entering the information about what it means and how it should be entered so that apples are compared to apples. As an example, Ms. Peek said they are working on the Comprehensive Addiction and Recovery Act (CARA) related to the plan of safe care when a baby with a substance in their system is delivered at a hospital. That falls under CARA reporting. When looking at the Division's data related to babies born with a substance in their system and Child Protective Services (CPS)'s data, they were different. It related to the ICD-10 codes. There are appropriate ICD-10 codes to use to describe this very specific population. She warned everyone to look at the disclaimers in Ms. Morgan's data. If the trends seem funny, it probably relates to the way the data was pooled. Modifications can be made.

7. Recommendations on AB 474 – NAC 441A Regulations

Ms. Peek said she would limit this to overdose reporting. To provide context, SEW has seen that overdose reporting is either hugely delayed—death data takes six or more months, EMS data has been incomplete—or based on the use of hospital discharge billing as proxy, which is not the best way to track the information. Governor Sandoval made overdoses reportable in AB 474, located in Nevada Administrative Code (NAC) 441A. The act became effective January 1, but the emergency regulations went into effect January 19. Prescribe365.nv.gov hosts a wealth of information, including a link titled "AB 474 Emergency Regulations." You can find that link here. These regulations are effective for 120 days. By then, permanent regulations should be in place. The small business impact statement was posted with draft regulations.

There was not a definition of "overdose" in statute, so Section 1.1 defines it. Section 2.1 states that the overdose must be reported within 7 days of patient discharge, so discharge was explained. After conversations with the Nevada Hospital Association, that was changed from 7 to 10 days. Overdose reporting for drugs scheduled I-IV is required even though AB 474, focusing on prescribing,

included only schedules II-IV. A lot of the information that mimics communicable disease reporting will be in the reports, with the addition of information regarding a patient's previous known overdoses and disposition. Specific ICD-10 codes are listed because it is easier for the reporters if it is detailed. Section 3 requires a medical facility to establish procedures for reporting. Hospitals and facilities are not required to report. This specifically requires physicians, veterinarians, nurses, and physician assistants to report because they are providers of health care as defined in *Nevada Revised Statutes* (NRS) 441.A. In spite of that, many facilities are stepping forward to report on behalf of their clinicians, which is the desired result. This week, Renown will be sending a test transfer based on the emergency regulations. If it is successful, it will be sent out to all the hospitals to see if it is something they could prepare as well. It would alleviate provider reporting and expedite reporting in a format that is much better than paper reporting. There is a one-page overdose reporting form that providers can fill out and fax that includes all the variables needed. The fax will be sent to the OPHIE office; it is not reportable at the local level. Some asked what would happen if they did not collect information such as previous known overdoses of a patient. If that is a question they do not ordinarily ask in a patient visit, they can leave it blank or mark it "unknown" or "not collected." If the information is collected or could be collected in the future, it is important information to collect. Some have asked if dentists need to report. They do not fall within the NRS 441.A regulations. Another question concerned if a clinician who is required to report finds out their patient overdosed six months ago and that was addressed and now the patient is in for a routine visit. Reporting is required only when the overdose is the primary reason for the visit with the clinician at that time. Those will be released in Frequently Asked Questions (FAQs) shortly.

Ms. Cartwright asked for clarification on which provider would be the best to report when a patient was treated for overdose by an entire team of health care providers. The other issue she wanted clarified regarded collecting medical records and ICD-10 codes. There is a phrase that says, ". . . a provider who knows of a patient. . ." She found the "knows of" language to be a bit ambiguous. Ms. Peek said that wording could be changed to, "the provider of health care who provided services." She said she would add to the FAQs Ms. Cartwright's question about when a team provides patient care could be incorporated into Section 3.1 regarding a procedure developed by a medical facility—the facility should designate which team member is required to report.

Dr. Azzam pointed out that if the facilities and the providers report, a high level of duplication could be expected. There should be a de-duplication process, especially if multiple members of a team report. Ms. Peek said they would make every effort to have the facility report on their behalf. If duplicate reports are received, they will be de-duplicated. She hoped the test with Renown would be successful. It would be a huge win for hospitals. She expected that ERs would be the bulk, if not the entirety, of the facility types that work with these patients.

Dr. Asteriadis Pyle wondered if hospice care was included in reporting. Dr. Azzam expressed that the nurse should be responsible to report the event if a patient died of an overdose. Ms. Peek replied that they receive duplicate reports from the physician and the nurse who was aware of the overdose. Dr. Azzam asked if the individual would be the provider if the patient was not in a facility. Mr. Delap thought this highlighted the issue of appropriate prescribing for intractable pain for someone with a terminal condition. He wondered if there were exceptions in some of the practices for prescribing, ordering, or dispensing of opiates in these cases. Ms. Monroy pointed out that orders differ from dispensed prescriptions. The protocols do not apply to hospital orders, but do apply to prescribed controlled substances, schedules II-IV for the treatment of pain. The protocols would apply to prescriptions written for hospice patients. She suggested a separate discussion with others who could provide the information more clearly. Mr. Delap pointed out that the death certificate of a hospice patient would show the cancer they died from, not an overdose. Ms. Peek said they would research the issue. Ms. Kerns agreed it was more than likely that the terminal illness would be considered the primary cause of death. Ms. Morgan pointed out that toxicology was done

if there was a suspected overdose. Dr. Azzam said if a patient had terminal cancer, the cancer would be the cause of death. Ms. Peek said this had implications—overdose death data should include hospice data as the intervention is not one to be prevented. The question is whether the practitioner would be required to report. Dr. Azzam said this would be considered comfort care, not an overdose. The clinician would want the patient to pass without suffering and pain, so this would not be considered an overdose. Ms. Kerns said that is part of hospice care. Mr. Egan said the coroner would not necessarily be involved in a hospice death. Hospice care deaths fall back onto the primary physician, not the coroner's office. Mr. Delap pointed out that if the treating physician signed the death certificate, there would not be an inquiry into cause of death. Mr. Egan said they would need clarification from the coroners' offices, but that is how he has seen it when someone was in hospice. Dr. Azzam said that, by definition, hospice is for people who have a life expectancy equal to or less than 180 days. Ms. Peek determined hospice information would not be relevant to overdose mortality data. She said she would add that hospices do not need to report in the FAQs. She suggested discussion with Dr. Fudenberg about this at the next meeting.

Ms. Long noted that reportable overdoses include drugs on schedules I-IV. She asked if OPHIE planned to add schedule V drugs. Ms. Peek asked for feedback from the group. OPHIE's subject matter experts recommended collecting data on schedule V drugs. Providers told them that was overkill and the amount of data would be a burden to report. Ms. Monroy asked if many people overdosed on schedule V drugs. Ms. Monroy said there is a problem if there is a big issue with people overdosing on schedule V drugs. Ms. Morgan said that schedule V drugs, by definition, have a low risk for addiction and high medical usage. Ms. Long said she is most concerned about the promethazine and codeine that a lot of students take. They mix them with alcohol with other controlled substances, which increases the risk for overdosing. If that medication is found in their bodies, she thinks the data should be collected. Nevada has a problem with fraudulent prescriptions. She thinks it would be worthwhile to add these drugs in now, rather than later. Ms. Cartwright said she has had internal discussions with psychiatrists. From a mental health perspective—not everybody overdoses on schedule I-IV medications. An adolescent attempting suicide might just grab everything in the medicine cabinet, using whatever was found there. She thought it might be useful to have the schedule V data included in order to see what people have available when they attempt suicide. Ms. Peek said it would be easy to add a field for this in the electronic reporting. She said she would make a draft for public hearing with schedule V and have it open for discussion. Ms. Morgan pointed out that only overdoses would be reported, so the number of reports should not increase much. Dr. Azzam did not think the number of reports would go up. He thought the situation would be missed if schedule V drugs were not included. Ms. Kerns pointed out that if someone overdosed on a schedule V drug in a suicide attempt, the next attempt might be on a schedule II-IV drug. Ms. Long said schedule Vs are not all other drugs; they are a small class of drugs that does not include antidepressants. Lyrica, promethazine, codeine and a few anti-seizure drugs would be included.

Ms. Peek said the edits she has would change the reporting period from 7 to 10 days. Section 2.1 will be changed to read, "No later than 10 days from patient discharge, the provider of health care who provided services to a patient who has suffered or is suspected of having suffered a drug overdose shall report each incident to the Chief Medical Officer or his or her designee."

Mr. Delap had a question whether data would specify identified intentional overdose toxicity with a non-scheduled drug. For context, he gave this example: A few years ago he was part of a patient's care. The patient had accidentally overdosed on a tricyclic class antidepressant. He wondered if they were trying to capture overdoses of anything, especially if the overdoses result in death or whether the focus was just on controlled substances. Ms. Morgan pointed out that death data and the hospital billing data uses ICD-10 codes for overdosing. The code will say overdosing/underdosing of the kind of drug, including antibiotics. Historically, OPHIE has not pulled and reported on those in relation to a drug overdose because those drugs are not being taken with the intention of misuse. Ms. Peek said there is latitude within AB 474—the prescribing

sections address schedules II, III, and IV for the treatment of pain. The changes to reporting did not specify any drugs. It can be made as broad as wanted. The understanding is to provide the data to prevent overdosing from occurring in the future. Ms. Morgan said it would be a major change to include schedule V, adding many ICD-10 codes. It would also be difficult to pull out underdosing from the overdosing. The exact term of the particular codes is, ". . . adverse effect of overdosing/underdosing from . . ." Mr. Egan said under the old CDC system, drug poisoning could be chosen. Under the new system, started in 2017, under poisoning, there are options: recreational drugs only, alcohol only, prescription and over-the-counter drugs, carbon monoxide, multiple drug combinations, and other specific poisons. He wondered if the Division wanted to separate the two now. Ms. Morgan said the CDC uses broad categories based on an underlying set. When writing the requirements for reporting, the Division would have to be more specific than a broad category, using ICD-10 codes to feed into the category. Dr. Azzam suggested differentiating between prescribed pain medication and over-the-counter pain medication. Ms. Peek said it was possible to differentiate in toxicology. The ICD-10s can do the same. Dr. Azzam pointed out that the State cannot control or stop naproxen overdoses because people can buy unlimited quantities. An attempted suicide would be captured by poison control centers. The concern here is overused or abused prescribed pain medication the State can control. Doctors will stop prescribing or change their patterns when they get feedback. If there is not a diagnosis for the patient, doctors should not prescribe. Back pain cannot be treated by medication—it could be caused by a herniated disc that requires surgery or microsurgery. In his opinion, the focus should be only on prescribed pain medications. Ms. Monroy agreed, saying this was why the Governor's Office worked on the bill. The focus should be on prescribed, controlled drugs for the treatment of pain. If there is an increase in overdoses as a result of illicit street drugs that were not prescribed, that would help the State and inform prevention strategies. Some providers and hospitals might push back on reporting because they do not know how to differentiate between someone prescribed Percocet and someone taking Percocet that is laced with something and purchased on the street. The intent of the bill was to expedite overdose data that was reported to OPHIE and the State to help inform strategies. Ms. Kerns added that a lot of the overdose deaths are not from the use of a single drug. Ms. Morgan said she looked at the ICD-10 T codes for the level of detail. Each of them starts with poisoning by, adverse effect of, and underdosing of whatever the drug is. Drugs are broken out separately, coding in details. For instance, opium can be broken out by accidental versus intentional self-harm versus assault versus undetermined. Heroin and opioids can be broken out with all that detail. Ms. Peek said overdose is T 40 through T 41.1. She wondered if there should be an additional set of T codes added. Ms. Morgan said the T codes cover opiates. The broad category T 40 is poisoning by, adverse effect of, and underdosing of narcotics and psychodysleptics and hallucinogens. T 36 is poisoning by, adverse effects of, and underdosing of systemic antibiotics. T 37 covers systemic anti-infectives and antiparasitics. Those are very different than the type of controlled substance considered when writing AB 474. To collect data on all poisonings would cover T 36 through T 50, which is a huge range of any drug you could have an adverse effect from. AB 474 specifies controlled substances. Dr. Asteriadis Pyle agreed that most of those impacted by prescription drugs or opioids would be captured by poison control. She wondered if someone who could not get hydrocodone would take too many ibuprofen or naproxen, information captured by poison control. It would be good to watch. Ms. Peek said they are tracking poison control data. Dr. Asteriadis Pyle did not think it needed to be part of the overdose reporting. Dr. Azzam said these could be unintended consequences. Ms. Peek said information could be obtained through hospital discharge billing. All of the codes could be put in the hospital discharge and death billing.

Ms. Peek asked for a motion that SEW recommends the edits as discussed—changing the number from 7 to 10 after discharge for the reporting to be done and the rewording in section 2. Dr. Azzam so moved. Dr. Asteriadis Pyle seconded the motion. The motion passed without opposition.

Ms. Peek said they were collecting small business impact statements. A summary will be given of what was reported. The next step will be public hearings where anyone can provide feedback on

the regulations. These should take place in mid-February. The regulations will to the Legislative Counsel Bureau to modify and make sure everything is correct. They should go to the Board of Health in April. They will become effective upon the Legislative Commission's approval and the signature of the Secretary of State. Ms. Peek added she would make the changes in the document for public hearing for feedback, and she will get the FAQs fixed and posted regarding the emergency regulations so they are available for providers.

8. Review of Current Membership and Upcoming Vacancies for Election at the Next Meeting
   Ms. Peek reported there were vacancies the group needed to talk about. She suggested members review the bylaws at the next meeting. The chair's term is two years, which Ms. Peek has completed. The bylaws mention a chair, a co-chair, and a vice-chair. In the even-numbered years, SEW is supposed to re-elect the co-chair, but Mr. Kuzhippala just started serving in this role. She suggested they look at changing the bylaws to have two co-chairs with opposite election years, each with a term of two years. Nominations should be sent to Ms. Peek. Nominations have to be submitted 30 days in advance of the next meeting. Any changes to the bylaws must be submitted 14 days in advance of the next meeting.
   The bylaws state that, after a member misses three consecutive meetings or three-quarters of the meetings in a year, they are automatically removed from membership. As a result, Jim Jobin from Vogue Recovery Center will be removed. He has not attended any meetings in the past year. A replacement for him should be somebody who could speak on behalf of one of the treatment providers. Mr. Delap does that now. If that is sufficient for the group, it would be unnecessary to replace Mr. Jobin's position. Ms. Peek said they would have to check the bylaws to determine if Ms. Henderson has to be elected by the members to replace Ms. Meuschke.

9. Behavioral Risk Factor Surveillance System and Youth Risk Behavior Survey System (YRBSS) Update
   Mr. Parrish provided an update regarding the questions for the 2018 BRFSS. The core questions were released recently. The survey is conducted from January to December; the University of Nevada, Las Vegas (UNLV) and UNR have started their phone calls. The core sections for this year are: health status, healthy days, health care access, exercise, inadequate sleep, chronic health conditions, oral health, demographics, tobacco use, alcohol consumption, immunization, falls, seat belt use, breast and cervical cancer screening, prostate cancer screening, colorectal cancer screening, and HIV/AIDS. These questions were last asked in 2016. There are about 40 state-added questions. The reason it is a higher number this year is some of the optional modules that the program selected were not offered as optional this year, so the ones from last year were turned into state-added questions. They include follow-ups for the random childhood selection questions and SAPTA perception questions that are asked every year. An example of a perception question is, How much do you think people risk harming themselves physically and in other ways when they use prescription drugs without a doctor's orders? There are also questions related to marijuana, hookah use, and the use of prescription drugs that are not prescribed to you as well as some adverse childhood experience questions. For the chronic diseases questions, there are questions regarding self-related intake and options that control high blood pressure. The tobacco program added a few questions regarding water pipes and hookahs. There are questions related to occupations for those who work in the hotel and casino industry. A few optional modules were selected: the random childhood selection, childhood asthma prevalence, and sexual orientation and gender identity. The survey will end the survey in December; the reports will be worked on during 2019.
   Mr. Kuzhippala asked if problem gambling questions were added. Mr. Parrish said Dr. Yang at UNR gave him two questions related to problem gambling that were included in the state-added questions.
   Ms. Henderson asked if the survey assesses for relationship violence and sexual assault. Mr. Parrish replied that the YRBS asked questions, but he did not think there were any in the BRFSS.

Relationship violence questions are part of the Adverse Childhood Experiences (ACEs) questions for the YRBS. Mr. Parrish reported that in the state-added questions there are seven questions related to the ACEs. Ms. Henderson mentioned she was concerned about peer-to-peer violence as a public health issue. She believes abused people self-medicate to cope, and that once the abuse factor is dealt with, the public health issues disappear. Ms. Peek said if questions were not added in time for this survey, they will be noted for a survey in the future.

Mr. Parrish said the YRBS is administered to middle school and high school students every other year. The last survey was done throughout the year in 2017, so UNR is working on the reports for them. Results will be sent to his office for review. He hopes to report in the next few months on UNR's website and the State's website. Ms. Peek explained that the most powerful thing about these two surveys is the ability to cross-tabulate to further delineate problems within a populations so someone can find out, for example, if females living in a certain geographic have problem gambling issues. Emails can be sent to data@dhhs.nv.gov to give DPBH specific questions SEW would like answered. SEW could also make a request for a presentation at a future meeting.

Mr. Parrish said the gambling questions for BRFSS are: In the past 12 months, how often have you bet money or possessions on any of the following activities—casino gaming including slot machines and table games; lottery—including scratch tickets, pull tabs, and Lotto; sports betting; internet gambling; bingo; and any other type of wagering? The follow-up question is, Has the money you spent gambling led to financial problems and/or has the time you spent gambling led to problems in your family, work, and personal life? Ms. Peek said this was the first time questions on this subject were being asked. Mr. Parrish said they were allowed to ask more state-added questions this year. He asked that if anyone had questions they would like to see on the next survey, they let him know. The charge for additional questions is usually $1,500 per question. He reported he would like to get a workgroup together this summer to select the questions for next year. Ms. Peek said she saw a presentation a student at UNR made on a study that looked at mining communities and substance use among their adolescents, using data from this survey.

Ms. DeLett-Snyder said it had been hard in the past for her to get BRFSS information for the Comprehensive Community Prevention Plans (CCPPs) in the coalition level. She could not get much more than one or two questions. She wondered if she could see the old reports. She also wanted to know if, with the YRBS, they will look by county and coalition and do individual reports for them. Ms. Peek said yes to both. Ms. Morgan said the YRBS report is done by UNR. The BRFSS reports are posted online. All historical reports for BRFSS can be found online. Ms. DeLett-Snyder can request information and how she wanted that information broken down. Ms. Peek said if what Ms. DeLett-Snyder wanted was something it would be helpful for them to add to the regular behavioral health reports they prepare for the coalitions that could be done.

Ms. Henderson asked about students who do not identify as male or female. There was discussion about whether that topic was covered in both the YRBS and the BRFSS. Ms. Peek said there was a question in BRFSS; DPBH pulled the data and presented it at a past SEW meeting. She suggested they could look at transgender data at the next meeting, cross-tabulating certain risks such as suicide and ideation. With data from multiple years, that information would be interesting to see.

Mr. Parrish said the BRFSS has a disclaimer about the next two questions being about sexual orientation and gender identity. The first question is, Which of the following best represents how you think of yourself and it give you the list options: lesbian/gay, straight, that is not gay, bisexual, something else, or I don't know. The following question is, Do you consider yourself to be transgender?

10. Handout for National Survey on Drug Use and Health

Dr. Azzam referred to the letter from the United States Department of Health and Human Services. The Center for Behavioral Health Statistics and Quality at Substance Abuse and Mental Health Services Administration (SAMHSA) contracted with RTI International, a nonprofit group, to conduct this year's survey on drug use and health. This extensive survey will take about one hour

to complete. RTI will interview about 70,000 individuals age 12 and older. Because of the nature of the survey and the fact that underage individuals can participate, there have been a lot of inquiries about its legitimacy in the past. They are attempting to be proactive this year, asking DPBH to disseminate information about the survey, which will be done in person. People under the age of 18 will need the permission of an adult in the household in order to be interviewed. Dr. Azzam said RTI will send 200,000 letters out across the nation, then randomly select 70,000 to be surveyed. Nevada's proportion should be around 700 letters and 500 individuals chosen. Ms. Peek said OPHIE has used this survey in the past to see how Nevada compares to other states on these measures. Dr. Azzam said this was a valuable survey.

11. Discuss Agenda Items for Next Meeting
    Ms. Peek reviewed items that would be in the agenda for the next meeting. There will be a review of the bylaws; nominations will be made for at least a chair or co-chair, depending on how members want to go with the bylaws, and there might be a nomination for another treatment representative; Mr. Erickson can speak to the results of the climate survey, if the results are ready. She pointed out that it is interesting to compare climate survey results to those of the YRBS as they differ. She would like Mr. Egan to present in more depth on suicide and to have Ms. Long report on what the Board of Pharmacy is seeing with the weekly data she collects on prescriptions. Ms. Peek would like to have Ms. Salla talk about juvenile justice data soon, or have her do a whole topic on adolescent health. If Ms. Morgan is ready to make an update on the criminal history repository related to overdoses after incarceration, it would be great. Ms. Peek said she will provide update on the regulations for overdose reporting and what is being done with the regulations related to law enforcement/jail medical reporting. Data on transgender will be pulled for at least BRFSS, if not YRBS. Ms. DeLett-Snyder asked if Mr. Erickson was the only one who could present the climate survey to this group. She thought SEW should ask the Department of Education. Washoe County asked questions about perceptions—questions the coalitions need because they do not appear in the YRBS. There is a grant her agency wants to write that asks if they can get the answers to the perceptions questions every other year. She is going to need the school district to see if they can put them back in, but they said they have requirements from the Department of Education. They took the drug-related questions out because they said they were getting good data. The perception questions were important. Ms. Peek said some perception questions were being added to YRBSS, so it is important to crosswalk the climate survey and YRBSS so they do not ask the questions twice. If something is being lost in entirety because of the Department of Education, there may be a way to add it into the YRBS. Mr. Parrish said the YRBSS has not had perception questions. That was something that PIRE requested. He talked with Dr. Clements-Nolle from UNR about this. She said PIRE always requests perception questions then, at the CDC level, they do not want perception questions. Some were added in the BRFSS, but not the YRBS. Ms. Peek asked why CDC does not want perception questions in YRBS. Mr. Parrish said he would check with UNR on that. Ms. Peek reported that Roseman University suggested doing away with YRBS and doing a much more comprehensive survey. They may come back again in the next legislative session to ask for that. It would probably contain perception questions. Mr. Kuzhippala asked if there could be a WITS update at the next meeting.

12. Public Comment
    Ms. Cartwright asked for confirmation that the emergency regulations listed on the website are the ones that go into effect January 18. Ms. Peek the edits will not be included. The ones online will go into effective when the Secretary of State signs them. She said the State will work with providers to roll this out. The FAQs and the form should be posted.

13. Adjourn
    The meeting adjourned at 11:17 a.m.